IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

Catholic Medical Association, on behalf of itself and its members, *Plaintiff*, v. **United States Department of Health and Human Services**; **Xavier Becerra**, in his official capacity as Secretary of the United States Department of Health and Human Services; **Centers for Medicare & Medicaid Services** of the United States Department of Health and Human Services; and **Chiquita Brooks-LaSure**, in her official capacity as Administrator of the Centers for Medicare & Medicaid Services of the United States Department of Health and Human Services, *Defendants*.	§	**Civil Action No. _____**

COMPLAINT

1. This case challenges a July 2022 Memorandum[1] and accompanying Letter[2] from Defendants the Centers for Medicare & Medicaid Services (CMS) of the

[1] Attached as Exhibit A, *Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss*, Centers for Medicare and Medicaid Services (July 11, 2022), https://www.cms.gov/files/document/qso-22-22-hospitals.pdf.

[2] Attached as Exhibit B, *Letter to Health Care Providers*, Secretary of HHS Xavier Becerra (July 11, 2022), https://www.hhs.gov/sites/default/files/emergency-medical-care-letter-to-health-care-providers.pdf.

United States Department of Health and Human Services (HHS), and HHS Secretary Xavier Becerra, respectively, which require hospitals and doctors to perform abortions, and purport to be authorized by the 1986 law the Emergency Medical Treatment and Labor Act (EMTALA).

2. The Memorandum and Letter (together, the "Mandate") exceed Defendants' statutory authority, were promulgated without procedure required by law, and are arbitrary and capricious, all in violation of the Administrative Procedure Act (APA). The Mandate also violates the rights of doctors under the Religious Freedom Restoration Act (RFRA) and the First Amendment.

JURISDICTION AND VENUE

3. This Court has subject-matter jurisdiction under 28 U.S.C. § 1331 because this action arises under the U.S. Constitution and federal law.

4. This Court has jurisdiction under 28 U.S.C. § 1346(a) because this is a civil action against the United States.

5. This Court has jurisdiction under 28 U.S.C. § 1361 to compel an officer of the United States or any federal agency to perform his or her duty.

6. The APA waives sovereign immunity and provides jurisdiction and a cause of action to review Defendants' actions and enter appropriate relief. 5 U.S.C. §§ 553, 701–06.

7. This Court has equitable jurisdiction and remedial power to review and enjoin ultra vires or unconstitutional agency action. *See Larson v. Domestic & Foreign Com. Corp.*, 337 U.S. 682, 689–91 (1949).

8. This case seeks declaratory, injunctive, and other appropriate relief under the APA, 5 U.S.C. §§ 701–06; the Declaratory Judgment Act, 28 U.S.C. §§ 2201–02; and Federal Rules of Civil Procedure 57 and 65.

9. This Court may award costs and attorneys' fees under the Equal Access to Justice Act, 28 U.S.C. § 2412, and 42 U.S.C. § 1988(b).

10. Venue is proper in this Court and this division under 28 U.S.C. § 1391, including paragraph (e).

11. A substantial part of the events or omissions giving rise to the claims occurred in this district and this division. The case in substantial part concerns Defendants' regulation of Plaintiff's members in this district and division.

12. Plaintiff Catholic Medical Association has members who reside and are regulated in this district, including Dr. Rachel Kaiser, M.D., identified below. No real property interest is involved in this action.

13. Defendants are agencies of the United States and officers and employees of the United States or of any of its agencies acting in their official capacity or under color of legal authority.

PARTIES

Plaintiff

14. Plaintiff Catholic Medical Association is a national, physician-led community that includes as members about 2500 physicians and healthcare providers nationwide in all fields of practice. CMA represents faithful Catholics in the healthcare field so that its members can grow in faith, maintain ethical integrity, and provide excellent healthcare in accordance with the teachings of the Catholic Church. CMA members oppose direct[3] abortion and categorically exclude providing medical interventions or referrals for direct abortion, including

[3] A "direct abortion" in the view of CMA is the directly intended termination of pregnancy, from fertilization but before viability, or the directly intended destruction of a living embryo or fetus. This does not include interventions that have as their direct purpose the cure of a proportionately serious pathological condition of the reproductive system which cannot be postponed until viability, as long as such interventions do not constitute a direct attack on the unborn child.

completing an incomplete chemical abortion. CMA is a nonprofit organization incorporated in Virginia, and its registered agent is in Virginia. CMA's principal place of business is in Pennsylvania. CMA sues on behalf of its members, including its identified member Dr. Rachel Kaiser in Nashville, Tennessee.

Defendants

15. Defendant United States Department of Health and Human Services is a cabinet-level agency of the United States government and enforces EMTALA. HHS's address is 200 Independence Avenue SW, Washington, DC 20201.

16. Defendant Xavier Becerra is the Secretary of HHS and issued the Letter challenged here (Ex. B). He is sued in his official capacity. His address is 200 Independence Avenue SW, Washington, DC 20201.

17. Defendant Centers for Medicaid and Medicare Services (CMS) is the division of HHS that administers the Medicaid and Medicare programs and issued the Memorandum challenged here (Ex. A). CMS's address is 7500 Security Boulevard, Baltimore, Maryland 21244.

18. Defendant Chiquita Brooks-LaSure is Administrator of CMS, which issued the Memorandum challenged here. Ms. Brooks-LaSure is sued in her official capacity. Her address is 7500 Security Boulevard, Baltimore, Maryland 21244.

BACKGROUND

I. EMTALA

19. Congress enacted EMTALA to prevent "patient dumping," which is the practice of refusing to treat patients who are unable to pay.

20. EMTALA requires that every Medicare-participating hospital provide medical screening and stabilizing treatment for emergency medical conditions regardless of a patient's ability to pay. 42 U.S.C. § 1395dd.

21. EMTALA defines "emergency medical condition" as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily function or part." 42 U.S.C. § 1395dd (e)(1)(A).

22. "To stabilize" means "to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility." 42 U.S.C. § 1395dd(e)(3)(A).

23. The Social Security Act, of which EMTALA is a part, states that "[n]othing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided … or to exercise any supervision or control over the administration or operation of any … institution, agency, or person [providing health services]." 42 U.S.C. § 1395.

24. EMTALA does not operate as federal oversight on the practice of medicine and does not create or authorize the creation of a national standard of care.

25. Instead, the standard of medical care is determined by the state and the community in which the treatment took place.

26. State laws regulating abortion, and state laws protecting conscientious objections to abortion, form an essential part of the standard of medical care and of the state's regulation of the practice of medicine.

27. With one notable exception, EMTALA, while requiring that stabilizing "medical treatment of the condition as may be necessary to assure … that no

material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility," does not mandate, direct, approve, or even suggest the provision of any specific treatment. 42 U.S.C. § 1395dd(e)(3)(A). That exception—"with respect to a pregnant woman who is having contractions" (i.e., in labor), and where "there is inadequate time to effect a safe transfer to another hospital before delivery, or … that transfer may pose a threat to the health or safety of the woman or the unborn child"—requires covered entities to "stabilize" meaning "to deliver (including the placenta)." 42 U.S.C. § 1395dd(e)(1)(B) & (e)(3)(A).

28. EMTALA also includes an anti-preemption provision. Congress specified that EMTALA "do[es] not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of [EMTALA]." 42 U.S.C. § 1395dd(f).

29. No federal statute or constitutional provision confers a right to abortion.

30. EMTALA says nothing about abortion and does not guarantee access to abortion.

31. Instead, EMTALA requires the stabilization of emergency medical conditions posing serious jeopardy to patients, including the "unborn child," and explicitly refers to the need to protect the "unborn child" four times. *See* 42 U.S.C. § 1395dd(c), (e).

32. Abortion does not stabilize the unborn child from serious jeopardy faced by an emergency medical condition, nor does it preserve the life or health of an unborn child.

33. EMTALA provides for civil enforcement actions against both hospitals and physicians. 42 U.S.C. § 1395dd(d). Hospitals and physicians are each subject to a civil penalty of up to $119,942 for each violation. Ex. A at 5. They may also be

excluded from participating in Medicare and other federal funding programs if they violate EMTALA.

II. HHS issues an abortion Mandate under EMTALA

34. On June 24, 2022, the Supreme Court overturned *Roe v. Wade*, 410 U.S. 113 (1973), and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992). *Dobbs v. Jackson Women's Health Organization*, 597 U.S. 215 (2022). The Court held that, contrary to the holdings of *Roe* and *Casey*, "the Constitution does not confer a right to abortion," *id.* at 292, nor does it "prohibit the citizens of each State from regulating or prohibiting abortion," *id.* at 302.

35. That same day, President Biden held a press conference declaring that "[t]he only way we can secure a woman's right to choose … is for Congress to restore the protections of *Roe v. Wade* as federal law."[4]

36. The next day, Secretary Becerra stated in an interview that Americans "can no longer trust" the Supreme Court.[5] When asked what he was doing in response to *Dobbs*, Secretary Becerra responded, "we're going to be aggressive and go all the way."[6]

37. The Mandate purports to override individual states' abortion laws under the authority of EMTALA.

---

[4] *Remarks by President Biden on the Supreme Court Decision to Overturn* Roe v. Wade, The White House (June 24, 2022), https://www.whitehouse.gov/briefing-room/speeches-remarks/2022/06/24/remarks-by-president-biden-on-the-supreme-court-decision-to-overturn-roe-v-wade/.

[5] *HHS Secretary Becerra Talks Women's Future with Abortion Following* Roe v. Wade *Decision* (NBC News broadcast June 25, 2022), https://www.nbcnews.com/video/women-s-future-with-abortion-implementing-harm-reduction-with-addiction-142836293922, at 1:45.

[6] *Id.* at 2:19, 2:59.

38. The Mandate was implemented through CMS, which issued the Memorandum to all State Survey Agency Directors (the officials who implement Medicare and Medicaid). *See* Ex. A.

39. At the same time, Secretary Becerra issued the Letter to all Medicare-participating Health Care Providers describing the Memorandum. Ex. B.

40. HHS and CMS did not provide notice and opportunity for public comment before issuing the Mandate.

41. In the Mandate, the agency purports to remind hospitals of their existing obligations under federal law. But the Mandate did not "remind" hospitals of anything; rather, it creates new requirements related to the provision of abortions—requirements that are found nowhere in EMTALA, any other federal law, or any past regulation or guidance enforcing EMTALA.

42. The Mandate requires that covered entities perform an abortion if "abortion is the stabilizing treatment necessary to resolve [an emergency medical condition]." Ex. A at 1.

43. This requirement has never been a part of EMTALA.

44. EMTALA does not mention abortion, require particular medical treatments, or set a nationwide standard of care. The only specific stabilizing treatment it mentions is delivery of the unborn child when a mother is in labor.

45. The Mandate omits the duty under EMTALA to stabilize the unborn child.

46. The Mandate states, "**[i]f a physician believes that a pregnant patient** presenting at an emergency department is experiencing an emergency medical condition as defined by EMTALA, and that abortion is the stabilizing treatment necessary to resolve that condition, the physician ***must*** provide that treatment." Ex. A at 1.

47. It then says that "[w]hen a state law prohibits abortion and does not include an exception for the life of the pregnant person—or draws the exception more narrowly than EMTALA's emergency medical condition definition—**that state law is preempted**." Ex. A at 1.

48. CMS also says the Mandate's preemption "could be enforced by individual physicians in a variety of ways, potentially including as a defense to a state enforcement action, in a federal suit seeking to enjoin threatened enforcement, or … under the statute's retaliation provision." Ex. A at 5.

49. This preemption has never been a part of EMTALA and contradicts 42 U.S.C. § 395dd(f).

50. As Spending Clause legislation, EMTALA cannot preempt state law.

51. Even if Spending Clause legislation could preempt state law, it cannot do so here where third parties—and not the state—agree to the funding condition.

52. The Hyde Amendment generally prohibits hospitals from using federal funds to pay for abortions. Consolidated Appropriations Act, 2024, Pub. L. 118-47, div. H, tit. V, §§ 506–07, 138 Stat. 460, 703.

53. The Weldon Amendment prevents the Department of Health and Human Services (HHS) from using federal funds to require a healthcare entity to facilitate abortion. *Id.* § 507(d)(1), 138 Stat. at 703.

54. Despite this prohibition, the Mandate wrongly requires abortion in hospitals receiving federal funds.

55. Many CMA members work at hospitals that are not run by a state, and there is no Spending Clause authority to preempt the application of a state law in private hospitals by virtue of those hospitals' receipt of Medicare funds.

56. The health conditions for which the Memorandum purports to require abortions are broader than the life of the mother exceptions found in state laws attempting to respect the life and wellbeing of the unborn child. For example, the

Mandate says it includes undefined "health" conditions of a pregnant woman, situations such as "incomplete medical abortion[s]," and situations that do not presently threaten the life of the mother but are "likely … to become emergent." Ex. A at 1, 3, 6.

57. The Mandate specifies that "an emergency medical condition that has not been stabilized" can include "a patient with an incomplete medical abortion," and that the sorts of abortion that EMTALA can require include "methotrexate therapy" or "dilation and curettage." Ex. A at 4, 6.

58. Thus, the Mandate seeks to force hospitals and physicians to "complete" medication abortions even where the pregnancy is not itself endangering a woman's life or health, and even if the abortion began elsewhere, even illegally.

59. The Mandate, by threatening to punish hospitals and physicians for choosing not to engage in abortion as a method to stabilize patients, threatens to second-guess the medical judgment or moral or religious beliefs of a hospital or physician, and to subject the hospital or physician to penalties after the fact for allegedly failing in their stabilization duty based on the new abortion standard of care set out in the Memorandum.

60. The risk of after-the-fact liability is not hypothetical. It is how EMTALA is enforced by HHS.

61. For instance, a physician or hospital could decline to complete a medication abortion, proposing instead to attempt to stabilize both the mother and the unborn child by administering progesterone. However, the refusing physician or hospital may be accused by CMS and its agents of violating the Mandate, triggering potential liability by CMS and HHS's Office of the Inspector General.

62. No federal statute, including EMTALA, supersedes or preempts the States' power to prohibit abortion.

III. State medical licensing requirements are not in direct conflict with any requirement of EMTALA. The Mandate conflicts with state laws protecting women and unborn children from the harms of abortion.

63. Abortion is unlawful and a criminal offense in many states and situations, including in Tennessee, which defines abortion as "the use of any instrument, medicine, drug, or any other substance or device with intent to terminate the pregnancy of a woman known to be pregnant with intent other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, to terminate an ectopic or molar pregnancy, or to remove a dead fetus." *See* Tenn. Code Ann. § 39-15-213(a)(1), (b) (Apr. 28, 2023).

64. Physicians' licenses to practice medicine in these states do not authorize them to perform illegal abortions. They may lose their medical licenses if they violate the law in their practice of medicine.

65. No state prohibits treatment of an ectopic pregnancy or management of a miscarriage (that is, a spontaneous abortion) under its pro-life laws restricting abortion.

66. All 50 states allow abortion when necessary to save the life of the mother. In states that restrict abortion, like Tennessee, there is an exception for procedures necessary to save the life of the mother or prevent serious injury to the mother. *E.g.*, Tenn Code Ann. § 39-15-213(c)(1)(A). Consistent with natural moral law and the teachings of the Catholic Church, as embraced by the Catholic Medical Association, no direct abortion, as defined in footnote 3, is justified even in such situations. Every effort is to be made to save the lives of the mother and unborn child. It is CMA's position that this can be accomplished, and if not, it may be possible to invoke the principle of double effect in situations identified by the *Ethical and Religious Directives for Catholic Health Care Services*: "Operations, treatments, and medications that have as their direct purpose the cure of a

proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child."[7]

67. Many states, including Tennessee, specify that the provision allowing abortion to save the life of or prevent serious injury to the mother cannot be invoked "based upon a claim or a diagnosis that the pregnant woman will engage in conduct that would result in her death or the substantial and irreversible impairment of a major bodily function or for any reason relating to the pregnant woman's mental health." Tenn. Code Ann. § 39-15-213(c)(2).

IV. Judicial review is proper.

A. The Mandate is final agency action.

68. The Mandate is final agency action subject to judicial review under the APA.

69. The Mandate reflects the culmination of the agency's decisionmaking process.

70. The Memorandum has an immediate effective date. Ex. A at 6.

71. The Mandate states that it creates a safe harbor for those who violate state law under its cover. *E.g.*, Ex. A at 5.

72. The Mandate sets out the agency's legal position on the meaning of EMTALA—in particular, how EMTALA applies after *Dobbs* and its relationship to conscience protections and RFRA—and binds the agency's personnel to its analytical method.

---

[7] U.S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* #47 (6th ed. 2018), https://www.usccb.org/resources/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06_3.pdf.

73. The Mandate takes the legal position that EMTALA's stabilization requirement preempts state laws prohibiting abortion by claiming such laws are in "direct conflict" with EMTALA. *E.g.*, Ex. A at 4.

74. The Mandate takes the legal position that EMTALA does not include a duty to stabilize the unborn child. Ex. A at 3 (omitting reference to an unborn child from its statement of the law).

75. The Mandate takes the legal position that any conflict between stabilizing the mother and stabilizing the unborn child must be resolved through abortion. Ex. B. at 1. It states, "if a physician believes that a pregnant patient … is experiencing an emergency medical condition as defined by EMTALA, and that abortion is the stabilizing treatment necessary to resolve that condition, the physician must provide that treatment." Ex. B. at 1.

76. The Mandate takes the legal position that EMTALA's stabilization requirement is triggered if a medical condition is "likely … to become emergent." Ex A at 1.

77. The agency commits itself to these legal positions. For example, the Letter promises that HHS "will take every action within our authority" to enforce the Memorandum, Ex. B. at 2.

78. These legal positions go beyond EMTALA.

79. The Mandate says nothing about the Mandate not being applicable when other laws protecting conscience or religious freedom would apply.

80. CMS has never modified the Mandate to clarify that it does not apply where conscience or religious freedom laws apply.

81. The Mandate is binding on HHS, CMS, and their officials.

82. Under the Mandate, HHS and CMS officials enforcing EMTALA are not free to reach conclusions opposite to the positions taken in the Mandate.

B. The Mandate threatens CMA members as regulated parties.

83. CMA is a national, physician-led community that includes about 2500 physicians and health professionals nationwide in all fields of practice. For its members, healthcare is not just a job but a sacred calling. CMA members care for all people without discrimination on the basis of sex or any other characteristic prohibited by law. A patient with medical needs, such as a sore throat, broken arm, HIV, miscarriage, or cancer, should be given the best care possible, regardless of the patient's identity.

84. CMA's mission is to represent faithful Catholics in the healthcare field so that its members can grow in faith, maintain ethical integrity, and provide excellent healthcare in accordance with the best medical standards of care and the teachings of the Catholic Church.

85. CMA members seek to be a voice of truth spoken in charity, defending the dignity of human life and showing how Catholic teachings on the human person improve the practice of medicine. CMA is a leading national voice on applying the principles of the Catholic faith to medicine. It publishes guidance on healthcare ethics, creates educational resources and events, and develops strategies for members to provide healthcare consistent with Catholic values. CMA advocates and litigates for members' freedoms.

86. CMA seeks relief from the Memorandum and Letter on behalf of its current and future members. Seeking such relief for all aspects of their practices is part of the mission of CMA as approved by its board of directors.

87. CMA is a nonprofit organization. CMA members join CMA voluntarily, help finance CMA activities with dues and donations, help elect CMA leaders, and serve in CMA leadership.

88. CMA's board of directors has eleven medical doctors, a chaplain who is also a medical doctor, a doctoral prepared registered nurse with an advanced degree

in maternal-child health and a pontifical license in the Canon Law of the Catholic Church, and a Catholic bishop who holds a doctorate of divinity.

89. CMA has local guilds (chapters) covering every region of the country and the military. CMA has two active Guilds in Tennessee: the Nashville Guild of the CMA and the St. Gianna Guild of Knoxville. Each guild has multiple physician members.

90. CMA members mainly are physicians. CMA tracks each member's years in practice as well as whether the member has retired from practice.

91. CMA members have deep, substantial, science-based and religious objections to abortions. Members hold the categorical view that direct abortions harm women, are fatal to unborn children, and are unethical. CMA and its members believe that the direct intentional killing of the unborn child through abortion is a grave evil, and that facilitating, referring for, or speaking in favor of that practice is impermissible.

92. CMA believes: "Abortion is not healthcare. As physicians and other healthcare professionals, we know that when we care for pregnant women, we are caring for two distinct patients. Our duty is to protect and preserve the lives of the patients whom we care for…. From the time the original Hippocratic Oath was introduced, there has been a clear separation of medical care from the intentional killing of human beings. The science is clear—at the moment of fertilization, a new distinct, living and whole human being comes into existence. Abortion, which is an action whose sole intent is to end this life, clearly violates the basic tenets of medical ethics."[8]

[8] CMA, (Nov. 2, 2021), https://www.cathmed.org/blog/2021/11/02/abortion-is-not-healthcare-a-message-from-the-alliance-for-hippocratic-medicine/.

93. CMA members' opposition to abortion is informed by their religious beliefs. The Catechism of the Catholic Church states: "Since the first century the Church has affirmed the moral evil of every procured abortion. This teaching has not changed and remains unchangeable. Direct abortion, that is to say, abortion willed either as an end or a means, is gravely contrary to the moral law."[9]

94. As Pope Francis has said, "Reason alone is sufficient to recognize the inviolable value of each single human life, but if we also look at the issue from the standpoint of faith, every violation of the personal dignity of the human being … is an offense against the Creator…. Unborn children [are] the most defenseless and innocent among us."[10]

95. CMA has resolved that it will "advocate for protection of pre-born babies, condemn any abortion, and … affirm with clarity the value of human life" and that it "supports the current Federal law which protects the physician from being coerced into referring for abortion."[11]

96. CMA Members' categorical exclusion of providing, facilitating, or affirming direct abortions, and commitment to state laws restricting certain abortions, precludes members from performing those abortions, helping complete those abortions, or referring for the abortions.

97. Providing, facilitating, referring for, or endorsing direct abortion violates the core religious beliefs of CMA members and their oaths to "do no harm."

---

[9] Catechism of the Catholic Church ¶ 2271, https://www.vatican.va/archive/ENG0015/__P7Z.HTM.

[10] Pope Francis, Apostolic Exhortation Evangelii Gaudium ¶ 213 (Nov. 24, 2013), https://www.vatican.va/content/dam/francesco/pdf/apost_exhortations/documents/papa-francesco_esortazione-ap_20131124_evangelii-gaudium_en.pdf.

[11] CMA, *Resolutions*, https://www.cathmed.org/resolutions.

98. The Mandate injures CMA members. Many CMA members work in hospitals subject to EMTALA and provide care in their emergency rooms to women in pregnancy-related situations.

99. The Mandate exerts government pressure on CMA members to violate those beliefs and makes it more difficult for the members to practice medicine according to their faith.

100. CMA has individual physician members, including in the Middle District of Tennessee, who actively practice medicine, who participate in HHS-funded federal healthcare programs, and who are subject to and affected by the Mandate, including one or more affected members in the Nashville division.

101. Dr. Rachel T. Kaiser of Nashville, Tennessee, is a member in good standing of CMA. She shares CMA's positions. Dr. Kaiser is representative of and similarly situated to CMA's members as a whole.

102. Dr. Kaiser is an emergency room (ER) doctor who sees Medicaid, Medicare, and CHIP patients on a contract basis at Ascension St. Thomas West Hospital in Nashville, Tennessee.

103. Dr. Kaiser considers both a pregnant woman and her unborn child to be human persons and her patients, and believes both are entitled to medical care and deserve the protection of the law. She wants to remain free to practice medicine according to her conscience and religious beliefs.

104. Dr. Kaiser routinely provides referrals to an OB/GYN for prenatal care and for miscarriage treatment after fetal demise has occurred. She often counsels pregnant ER patients in ways that affirm the value of unborn life. She refers patients to a local pregnancy care center—she does not refer for abortions.

105. At least once a year, ER patients ask Dr. Kaiser for an abortion or for another procedure that could end the life of an unborn child. At times, ER patients also ask for abortion referrals. Dr. Kaiser does not provide these procedures or

referrals. She expects she will continue to receive similar requests for abortions or abortion referrals, which she will continue to decline.

106. Dr. Kaiser will not perform, refer for, or participate in elective abortions. If a pregnant woman presented to the ER after an attempted chemical abortion and her unborn child was still living, Dr. Kaiser would stabilize the mother, if necessary, and also offer intervention to try to save the unborn child's life. She would offer to prescribe progesterone for mothers who want to try to counter the effects of mifepristone and save their unborn children. But Dr. Kaiser is afraid she would be violating the CMS memorandum's interpretation of EMTALA if she declined to complete an incomplete medication abortion where the child is still living.

107. In her practice as an ER physician, Dr. Kaiser complies with Tennessee's laws protecting unborn children and she intends to continue to do so. She will not perform, participate in, or refer for any unlawful abortion. If the Mandate requires her to perform, participate in, or refer for unlawful abortions or elective abortions, Dr. Kaiser might be forced to give up her medical practice.

108. The Memorandum and Letter have been enjoined as to the plaintiffs in *Texas v. Becerra*: the State of Texas, and members of the American Association of Pro-Life Obstetricians & Gynecologists (AAPLOG) and the Christian Medical & Dental Associations (CMDA). *See* 89 F.4th 529 (5th Cir. 2024), *cert. denied* No. 23-1076, 2024 WL 4426546 (U.S. Oct. 7, 2024).

109. Many of CMA's members are not protected by the *Texas v. Becerra* judgment, because they are not members of AAPLOG or CMDA, and they practice medicine outside of Texas.

110. Dr. Kaiser is not a member of AAPLOG or CMDA, and practices medicine outside of Texas.

111. These CMA members need a court order protecting them from the Mandate.

112. Other than acknowledging the injunction from *Texas v. Becerra* that does not encompass the CMA's members, Defendants have never modified or withdrawn the Mandate, either in whole or in part. *See* Ex. A.

113. The Mandate is still in force at the time this case is filed.

114. The Mandate impacts CMA's members as individual physicians who are regulated by HHS, including CMS.

115. If CMA members were to comply with the Mandate's interpretation of EMTALA, they would lose their professional and personal integrity and reputation of practicing with sound judgment and good medical ethics, making patients less likely to trust them, and driving patients and employees away from their practices.

116. If CMA's members do not comply with the Mandate's interpretation of EMTALA, they will be violating a federal regulatory dictate, and will be subject to investigations and enforcement actions, losing time, money, and resources that they could use for medical care, as well as putting their jobs and medical licenses at risk.

117. The Mandate's looming threat of government penalties burdens the free exercise of religion of CMA's members. The decisions they make in emergency room settings can be sensitive, complex, rushed, and time-limited. They make their utmost effort to protect all of their patients, including the unborn, based on their medical, ethical, and conscientious judgments. Injecting government pressure to assist or complete abortions into those delicate situations necessarily burdens the medical, ethical, and religious decision-making that CMA's members engage in while in emergency room settings.

118. CMA members have a religious objection to being used as a link in the abortion-product chain. Yet this is exactly what happens when, for example, abortion drugs are mailed to women in pro-life states or prescribed to them in

nearby states—women take them at home instead of in a medical office, and prescribers, pharmaceutical companies, HHS, and other federal agencies tell those women to go their local emergency room if there are complications. HHS through the Mandate insists that CMA's member doctors and their Medicare-participating hospitals must assist or complete such chemical abortions, rather than allowing the physician to engage in scientifically defensible treatments to address the wellbeing of both the mother and unborn child.

119. The Mandate will drive members of CMA out of the medical profession, and it will dissuade CMA medical students from choosing to practice emergency medicine, narrowing their career options and reducing care for underserved, low-income, and rural patients.

120. The Mandate imposes irreparable harm on CMA's members.

121. CMA and its members have no adequate remedy at law.

CLAIMS FOR RELIEF

COUNT I
Administrative Procedure Act: Contrary to Law
5 U.S.C. § 706(2)(A)–(C)

122. Plaintiff re-alleges and incorporates herein, as though fully set forth, paragraphs 1–121 of this complaint.

123. The Court shall hold unlawful and set aside agency action undertaken: not in accordance with law; in excess of statutory jurisdiction, authority, or limitations; short of statutory right; or contrary to constitutional right, power, privilege, or immunity. 5 U.S.C. § 706(2)(A)–(C).

124. EMTALA does not authorize the Mandate.

125. EMTALA nowhere allows Defendants to require abortions or to establish a nationwide standard of care requiring abortions.

126. Instead, in EMTALA Congress denied Defendants authority to mandate abortions by requiring that the "unborn child" be stabilized.

127. Defendants do not have statutory authority to exercise "any supervision or control over the practice of medicine or the manner in which medical services are provided." 42 U.S.C. § 1395.

128. EMTALA does not preempt state law, and as conditional spending legislation it cannot preempt state law.

129. There is no abortion mandate clear in the text of the EMTALA mandate to satisfy the requirement for imposing Spending Clause conditions.

130. EMTALA "do[es] not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of [EMTALA]." 42 U.S.C. § 1395dd(f).

131. State laws regulating the practice of medicine by prohibiting abortion or limiting the scope of licensed medical practice to lawful conduct are not in "direct" conflict with EMTALA's stabilization requirement or any other requirement in EMTALA.

132. Tennessee law restricting abortion does not directly conflict with any requirement of EMTALA.

133. EMTALA's stabilization requirement encompasses medical treatments that are "available." 42 U.S.C. § 1395dd(b)(1)(A). Illegal procedures, like an abortion prohibited by state law, or abortions for which physicians and hospitals have the right to object to performing, are not "available" as stabilizing treatment.

134. The Weldon Amendment to annual appropriations laws prohibits federal agencies from discriminating against any institutional or individual health care entity "on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions." *See, e.g.*, Consolidated Appropriations Act § 507(d)(1).

135. The Coats-Snowe Amendment prohibits "[t]he Federal Government" from discriminating against any healthcare entity on the basis that it refuses to perform induced abortions or to provide referrals for such abortions. 42 U.S.C. § 238n.

136. The Mandate violates the Weldon and Coats-Snowe Amendments.

137. The Religious Freedom Restoration Act (RFRA) prohibits Defendants from imposing a substantial burden on religious exercise unless doing so is the least restrictive means of advancing a compelling government interest. 42 U.S.C. § 2000bb-1.

138. The Mandate violates RFRA.

139. The Free Exercise Clause of the First Amendment prohibits Defendants from compelling physicians to participate in, refer for, or otherwise facilitate abortions in violation of their religious beliefs.

140. The Mandate violates the Free Exercise Clause.

141. No other federal law authorizes the Mandate.

142. Because the Mandate contradicts EMTALA's text and other laws, and exceeds the agency's statutory and constitutional authority, it must be held unlawful and set aside.

COUNT II
Administrative Procedure Act: Without Required Procedure
5 U.S.C. § 706(2)(D)

143. Plaintiff re-alleges and incorporates herein, as though fully set forth, paragraphs 1–121 of this complaint.

144. The Court shall hold unlawful and set aside agency action undertaken without observance of procedure required by law. 5 U.S.C. § 706(2)(D).

145. The Medicare Act requires that the agency conduct notice and comment before issuing any rule, requirement, or statement of policy that changes a

substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits. 42 U.S.C. § 1395hh(a)(2), (b).

146. The Mandate is a rule, a requirement, and a statement of policy that changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under the Medicare Act.

147. The APA requires notice and comment for a legislative or substantive rule.

148. The Mandate is a legislative or substantive rule.

149. The APA requires the Court to hold unlawful and set aside any action an agency undertook without procedure required by law.

150. The agency failed to conduct notice and comment before issuing the Mandate, which was a procedure required by the Medicare Act and the APA.

151. Because Defendants acted without observance of the procedure required by law in issuing the Mandate, it must be held unlawful and set aside.

COUNT III
Administrative Procedure Act:
Arbitrary, Capricious, and Abuse of Discretion
5 U.S.C. § 706(2)(A)

152. Plaintiff re-alleges and incorporates herein, as though fully set forth, paragraphs 1–121 of this complaint.

153. The Court shall hold unlawful and set aside agency action undertaken in a way that is arbitrary, capricious, or an abuse of discretion. 5 U.S.C. § 706(2)(A).

154. When issuing the Mandate, the agency entirely failed to consider or even discuss important aspects of the problem, rendering it arbitrary and capricious.

155. Defendants failed to consider how the Mandate interacts and conflicts with conscience protections for individual physicians and entities.

156. Defendants failed to consider how the Mandate conflicts with the religious liberty interests of Medicare providers, including their rights under RFRA and the First Amendment's Free Exercise Clause.

157. Defendants failed to consider the limits on Congress' spending power, including the legal principles limiting conditional spending and providing that conditions on federal spending do not preempt state law.

158. Defendants failed to consider that the Social Security Act and EMTALA have anti-preemption clauses precluding the Mandate.

159. Defendants failed to consider that the Social Security Act does not regulate the practice of medicine and EMTALA does not authorize any federal agency to establish a standard of care by requiring abortions.

160. Defendants failed to consider that the Mandate conflicts with the Hyde and Weldon Amendments which prevent the use of federal funds to facilitate abortion and prevent imposing federal penalties on doctors hospitals and doctors because they decline to facilitate abortions.

161. Defendants failed to consider the reliance interests of hospitals and physicians who have practiced under EMTALA for decades without the Mandate.

162. The Mandate does not acknowledge the agency's change in position from never having previously required abortions or violations of state law under EMTALA, and as a result failed to explain that change in position.

163. Defendants offered no reasoned explanation for how EMTALA can require abortions when EMTALA requires stabilizing the "unborn child."

164. Defendants discussed no alternative approaches.

165. Because the Mandate is arbitrary, capricious, and an abuse of discretion under the APA, it must be held unlawful and set aside.

COUNT IV
Religious Freedom Restoration Act
42 U.S.C. § 2000bb-1

166. Plaintiff re-alleges and incorporates herein, as though fully set forth, paragraphs 1–121 of this complaint.

167. RFRA prohibits the federal government from substantially burdening a person's exercise of religion, unless the government proves that the burden is the least restrictive means of furthering a compelling government interest. 42 U.S.C. § 2000bb-1.

168. CMA asserts the rights of its members under RFRA.

169. CMA's members exercise their religious beliefs in practicing medicine by caring for patients generally, and in caring for patients in situations subject to EMTALA. CMA's members exercise their religious beliefs in treating pregnant women and their unborn children with respect and dignity, and in opposing involvement in the direct and intentional killing of unborn children in abortion.

170. The Mandate substantially burdens the exercise of CMA's members' sincerely held religious beliefs.

171. The Mandate imposes significant pressure on CMA's members to practice medicine in way that would violate their beliefs because of the threat of investigations, fines, and other punishments and impairments.

172. The Mandate is not supported by a compelling government interest and is not the least restrictive means of advancing such an interest.

173. Upon information and belief, the Mandate specifically and primarily burdens religious conduct, favors some religious beliefs over others, and is motivated by animus and hostility towards the religious beliefs of pro-life physicians and hospitals.

174. The Mandate, and Defendants' enforcement thereof, violate the rights of CMA's members under RFRA.

COUNT V
Free Exercise Clause of the First Amendment

175. Plaintiff re-alleges and incorporates herein, as though fully set forth, paragraphs 1–121 of this complaint.

176. Under the First Amendment to the U.S. Constitution, "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof …." U.S. Const. amend. I.

177. CMA asserts the rights of its members under the Free Exercise Clause.

178. The First Amendment protects CMA members in their exercise of religion from the actions of Defendants in issuing and enforcing the Mandate.

179. CMA's members exercise their religious beliefs in practicing medicine by caring for patients generally, and in caring for patients in situations subject to EMTALA. CMA's members exercise their religious beliefs in treating pregnant women and their unborn children with respect and dignity, and in opposing involvement in the direct and intentional killing of unborn children in abortion.

180. The Mandate substantially burdens the exercise of CMA's members' sincerely held religious beliefs.

181. The Mandate exerts significant pressure on CMA's members to violate their beliefs in order to keep providing healthcare in federally funded health programs and activities or else face exclusion from those programs, loss of funding, loss of livelihood, and fines, investigations, and other punishments.

182. The Mandate is not neutral or generally applicable.

183. The Mandate affords discretion to enforcement officials to decide when an offense has occurred and whether and how to apply investigations or punishments.

184. Upon information and belief, the Mandate specifically and primarily burdens religious conduct, favors some religious beliefs over others, and is motivated by animus and hostility towards the religious beliefs of pro-life physicians and hospitals.

185. The Mandate is not supported by a compelling government interest and is not the least restrictive means of advancing such an interest.

186. The Mandate, and Defendants' enforcement thereof, violates the rights of CMA's members under the Free Exercise Clause of the First Amendment.

PRAYER FOR RELIEF

For these reasons, Plaintiff respectfully requests that the Court:

A. Hold the Mandate unlawful, set it aside, and vacate it. 5 U.S.C. § 706(2).

B. Declare the Mandate and Defendants' actions to enforce the Mandate to be unlawful. 28 U.S.C. § 2201.

C. Issue an injunction prohibiting Defendants from enforcing the Mandate.

D. Award Plaintiff its costs and reasonable attorney's fees.

E. Award any other relief that is equitable and just.

Respectfully submitted this 10th day of January, 2025.

/s/ Jonathan A. Scruggs
Jonathan A. Scruggs
TBPR No. 025679 (admitted 11/13/2006)
AZ Bar No. 030505
Alliance Defending Freedom
15100 North 90th Street
Scottsdale, Arizona 85260
Telephone: 480-444-0020
Facsimile: 480-444-0028
jscruggs@ADFlegal.org

Counsel for Plaintiff

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality

Ref: QSO-22-22-Hospitals

Revised 8/25/2022

DATE: **July 11, 2022**

TO: State Survey Agency Directors

FROM: Directors, Quality, Safety & Oversight Group (QSOG) and Survey & Operations Group (SOG)

SUBJECT: Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss (QSO-21-22-Hospitals- UPDATED JULY 2022)

Memorandum Summary

Pursuant to the preliminary injunction in Texas v. Becerra, No. 5:22-CV-185-H (N.D. Tex.), HHS may not enforce the following interpretations contained in the July 11, 2022, CMS guidance (and the corresponding letter sent the same day by HHS Secretary Becerra):
(1) HHS may not enforce the Guidance and Letter's interpretation that Texas abortion laws are preempted by EMTALA; and
(2) HHS may not enforce the Guidance and Letter's interpretation of EMTALA—both as to when an abortion is required and EMTALA's effect on state laws governing abortion—within the State of Texas or against the members of the American Association of Pro Life Obstetricians and Gynecologists (AAPLOG) and the Christian Medical and Dental Association (CMDA).

- ***The Emergency Medical Treatment and Labor Act (EMTALA)*** *provides rights to any individual who comes to a hospital emergency department and requests examination or treatment. In particular, if such a request is made, hospitals must provide an appropriate medical screening examination to determine whether an emergency medical condition exists or whether the person is in labor. If an emergency medical condition is found to exist, the hospital must provide available stabilizing treatment or an appropriate transfer to another hospital that has the capabilities to provide stabilizing treatment. The EMTALA statute requires that all patients receive an appropriate medical screening examination, stabilizing treatment, and transfer, if necessary,* ***irrespective of any state laws or mandates that apply to specific procedures.***
- ***The determination of an emergency medical condition*** *is the responsibility of the examining physician or other qualified medical personnel. An emergency medical condition may include a condition that is likely or certain to become emergent without stabilizing treatment. Emergency medical conditions involving pregnant patients may include, but are not limited to, ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders, such as preeclampsia with severe features.*
- ***Hospitals should ensure all staff*** *who may come into contact with a patient seeking examination or treatment of a medical condition are aware of the hospital's obligation under EMTALA.*
- ***A physician's professional and legal duty*** *to provide stabilizing medical treatment to a patient who presents under EMTALA to the emergency department and is found to have an emergency medical condition* ***preempts any directly conflicting state law or mandate*** *that might otherwise prohibit or prevent such treatment.*
- ***If a physician believes that a pregnant patient*** *presenting at an emergency department is experiencing an emergency medical condition as defined by EMTALA, and that abortion is the stabilizing treatment necessary to resolve that condition, the physician* ***must*** *provide that treatment. When a state law prohibits abortion and does not include an exception for the life of the pregnant person — or draws the exception more narrowly than EMTALA's emergency medical condition definition — **that state law is preempted**.*

NOTE: This memorandum is being issued to remind hospitals of their existing obligation to comply with EMTALA

Background

The purpose of this memorandum is to restate existing guidance for hospital staff and physicians regarding their obligations under the Emergency Medical Treatment and Labor Act (EMTALA), in light of new state laws prohibiting or restricting access to abortion.

The EMTALA statute is codified at section 1867 of the Social Security Act, 42 U.S.C. § 1395dd. Hospitals and physicians generally have three obligations under EMTALA.[1] The first is commonly referred to as the *screening requirement*, and applies to any individual who comes to the emergency department for whom a request is made for examination or treatment of a medical condition, including people in labor or those with an emergency condition such as an ectopic pregnancy. Such an individual is entitled to have a medical screening examination to determine whether an emergency medical condition (EMC) exists. The second obligation is commonly referred to as the *stabilization requirement*, which applies to any individual who comes to the hospital whom the hospital determines has an emergency medical condition. Such an individual is entitled to stabilizing treatment within the capability of the hospital. The third obligation flows from the second, and also applies to any individual in a hospital with an emergency medical condition. This obligation is sometimes known as the *transfer requirement*, which restricts the ability of the hospital to transfer that individual to another hospital unless the individual is stabilized. If the individual is not stabilized, they may only be transferred if the individual requests the transfer or if the medical benefits of the transfer outweigh the risks (e.g., the hospital does not have the capability to stabilize the condition).

While a patient may request a transfer for any reason, a hospital is restricted by EMTALA to transfer patients only after a physician certifies that the medical benefits of the transfer outweigh the risks. The EMTALA regulation at 42 CFR §489.24 clarifies that the screening requirement applies to any individual who presents to an area of the hospital that meets the definition of a "dedicated emergency department" and makes a request for a medical screening examination. The regulation defines dedicated emergency department as the area of the hospital that met any one of three tests: that it is licensed by the state as an emergency department; that it holds itself out to the public as providing emergency care; or that during the preceding calendar year, at least one-third of its outpatient visits were for the treatment of emergency medical conditions. Based on this definition, it is likely that the labor and delivery unit of a hospital could meet the definition of dedicated emergency department.

Medicare Conditions of Participation

Hospitals are also bound by the Medicare conditions of participation (CoPs) to provide appropriate care to inpatients (42 C.F.R. 482.1 through 482.58). In particular, four CoPs are potentially applicable when a hospital provides treatment for an admitted patient. For example, the governing body must ensure that the medical staff as a group is accountable to the governing body for the quality of care provided to patients (42 C.F.R. 482.12(a)(5) and 42 C.F.R. 482.22). Further, the discharge planning CoP (42 C.F.R. 482.43), which requires that hospitals have a discharge planning process, applies to all patients. Finally, the hospital governing body must ensure that the hospital has an organization-wide quality assessment and performance improvement program to evaluate the provision of patient care (42 C.F. R. 482.21). These CoPs are intended to protect patient health and safety, and to ensure that high quality medical care is

[1] Appendix V of the CMS State Operations Manual-: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_V_emerg.pdf

provided to all patients. Failure to meet these CoPs could result in a finding of noncompliance at the condition level for the hospital and lead to termination of the hospital's Medicare provider agreement.

EMTALA

There are several specific provisions we wish to call attention to under EMTALA[i] :

Emergency Medical Condition (EMC):

Once an individual has presented to the hospital seeking emergency care, the determination of whether an Emergency Medical Condition exists is made by the examining physician(s) or other qualified medical personnel of the hospital.

An EMC includes medical conditions with acute symptoms of sufficient severity that, in the absence of immediate medical attention, could place the health of a person (including pregnant patients) in serious jeopardy, or result in a serious impairment or dysfunction of bodily functions or any bodily organ. Further, an emergency medical condition exists if the patient may not have enough time for a safe transfer to another facility, or if the transfer might pose a threat to the safety of the person.

Labor

"Labor" is defined to mean the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A person experiencing contractions is in true labor, unless a physician, certified nurse-midwife, or other qualified medical person acting within their scope of practice as defined in hospital medical staff bylaws and State law, certifies that, after a reasonable time of observation, the person is in false labor.

Medical Screening Examination

Individuals coming to the "emergency department" must be provided a medical screening examination appropriate to the presenting signs and symptoms, as well as the capability and capacity of the hospital. Depending on the individual's presenting signs and symptoms, an appropriate medical screening exam can involve a wide spectrum of actions, ranging from a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures, such as (but not limited to) lumbar punctures, clinical laboratory tests, CT scans, and/or other diagnostic tests and procedures. The medical record must reflect continued monitoring according to the individual's needs until it is determined whether or not the individual has an EMC and, if they do, until they are stabilized or appropriately transferred. There should be evidence of this ongoing monitoring prior to discharge or transfer.

People in Labor

- Regardless of State laws, requirements, or other practice guidelines, EMTALA requires that a person in labor may be transferred only if the individual or their representative requests the transfer after informed consent or if a physician or other qualified medical personnel signs a certification at the time of transfer, with respect to the person in labor, that "the benefits of the transfer to the woman and/or the

unborn child outweigh its risks."[2] For example, if the hospital does not have staff or resources to provide obstetrical services, the benefits of a transfer may outweigh the risks.

- **A hospital cannot cite State law or practice as the basis for transfer.** Fear of violating state law through the transfer of the patient cannot prevent the physician from effectuating the transfer nor can the physician be shielded from liability for erroneously complying with state laws that prohibit services such as abortion or transfer of a patient for an abortion when the original hospital does not have the capacity to provide such services. When a direct conflict occurs between EMTALA and a state law, EMTALA must be followed.

- Hospitals that are not capable of handling high-risk deliveries or high-risk infants often have written transfer agreements with facilities capable of handling high-risk cases. The hospital must still meet the screening, treatment, and transfer requirements.

Stabilizing Treatment

After the medical screening has been implemented and the hospital has determined that an emergency medical condition exists, the hospital must provide stabilizing treatment within its capability and capacity. Section 42 CFR 489.24(b) defines **stabilized** to mean:

> "… that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or with respect to an "emergency medical condition" as defined in this section under paragraph (2) of that definition…."

The EMTALA statute requires that stabilizing treatment prevent material deterioration and compels hospitals and physicians to act prior to the patient's condition declining. The course of stabilizing treatment is under the purview of the physician or qualified medical personnel. If qualified medical personnel determine that the patient's condition, such as an ectopic pregnancy, requires stabilizing treatment to prevent serious jeopardy to the patient's health (including a serious impairment or dysfunction of bodily functions or any bodily organ or a threat to life), the qualified medical personnel is required by EMTALA to provide the treatment.

As indicated above, the determination of an emergency medical condition is the responsibility of the examining physician or other qualified medical personnel. Emergency medical conditions involving pregnant patients may include, but are not limited to: ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders, such as preeclampsia with severe features. The course of treatment necessary to stabilize such emergency medical conditions is also under the purview of the physician or other qualified medical personnel. Stabilizing treatment could include medical and/or surgical interventions (e.g., methotrexate therapy, dilation and curettage (D&C), removal of one or both fallopian tubes, anti-hypertensive therapy, etc.).

[2] State Operations Manual: Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases, 52, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_v_emerg.pdf.

Hospital's Obligation
A hospital's EMTALA obligation ends when a physician or qualified medical person has made a decision:

- That no emergency medical condition exists (even though the underlying medical condition may persist);
- That an emergency medical condition exists and the individual is appropriately transferred to another facility; or
- That an emergency medical condition exists and the individual is stabilized or admitted to the hospital for further stabilizing treatment.

Any state that has a more restrictive definition of emergency medical condition or that has a definition that directly conflicts with any definition above is preempted by the EMTALA statute. Physicians and hospitals have an obligation to follow the EMTALA definitions, even if doing so involves providing medical stabilizing treatment that is not allowed in the state in which the hospital is located. Hospitals and physicians have an affirmative obligation to provide all necessary stabilizing treatment options to an individual with an emergency medical condition.

The EMTALA statute requires that all patients receive an appropriate medical screening, stabilizing treatment, and transfer, if necessary, irrespective of any state laws or mandates that apply to specific procedures.

A physician's professional and legal duty to provide stabilizing medical treatment to a patient who presents to the emergency department and is found to have an emergency medical condition preempts any directly conflicting state law or mandate that might otherwise prohibit such treatment. EMTALA's preemption of state law could be enforced by individual physicians in a variety of ways, potentially including as a defense to a state enforcement action, in a federal suit seeking to enjoin threatened enforcement, or, when a physician has been disciplined for refusing to transfer an individual who had not received the stabilizing care the physician determined was appropriate, under the statute's retaliation provision.

Enforcement

HHS, through its Office of the Inspector General (OIG), may impose a civil monetary penalty on a hospital ($119, 942 for hospitals with over 100 beds, $59,973 for hospitals under 100 beds/per violation) or physician ($119,942/violation) pursuant to 42 CFR §1003.500 for refusing to provide either any necessary stabilizing care for an individual presenting with an emergency medical condition that requires such stabilizing treatment, or an appropriate transfer of that individual if the hospital does not have the capacity to stabilize the emergency condition. Under this same authority, HHS OIG may also exclude physicians from participation in Medicare and State health care programs. CMS may also penalize a hospital by terminating its provider agreement. Additionally, private citizens who are harmed by a physician's or hospital's failure to provide stabilizing treatment may file a civil suit against the hospital to obtain damages available under the personal injury laws of that state in which the hospital is located, in addition to recouping any equitable relief as is appropriate. 42 U.S.C. § 1395dd(d)(2)(A).

Any state actions against a physician who provides an abortion in order to stabilize an emergency medical condition in a pregnant individual presenting to the hospital would be

preempted by the federal EMTALA statute due to the direct conflict with the "stabilized" provision of the statute. Moreover, EMTALA contains a whistleblower provision that prevents retaliation by the hospital against any hospital employee or physician who refuses to transfer a patient with an emergency medical condition that has not been stabilized by the initial hospital, such as a patient with an emergent ectopic pregnancy, or a patient with an incomplete medical abortion.

To file an EMTALA complaint, please contact the appropriate state survey agency: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/ContactInformation

Individuals who believe they have been discriminated against on the basis of race, color, national origin, sex (including sexual orientation, gender identity, and pregnancy), age, disability, religion, or the exercise of conscience in programs or activities that HHS directly operates or to which HHS provides federal financial assistance, may file a complaint with the HHS Office for Civil Rights at http://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html.[3] With regard to civil rights protections against national origin discrimination, hospitals covered by EMTALA must take reasonable steps to provide meaningful access to their programs and activities by persons with limited English proficiency (LEP). In most cases, hospitals must provide some form of language assistance service, such as provide an interpreter at no cost to the patient or provide important documents translated into the patient's preferred language. Hospitals may learn more about their obligations to persons with LEP by visiting the HHS *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*.

Contact: Questions about this memorandum should be addressed to QSOG_Hospital@cms.hhs.gov.

Effective Date: Immediately. This policy should be communicated to all survey and certification staff and managers immediately.

/s/

Karen L. Tritz
Director, Survey & Operations Group

David R. Wright
Director, Quality, Safety & Oversight Group

cc: Survey and Operations Group Management
Office of Program Operations and Local Engagement (OPOLE)
Centers for Clinical Standards and Quality (CCSQ)

[3] For more information about the laws and regulations enforced by OCR, please visit https://www.hhs.gov/civil-rights/for-providers/laws-regulations-guidance/laws/index.html.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

July 11, 2022

VIA ELECTRONIC MAIL

Dear Health Care Providers:

In light of the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization,* I am writing regarding the Department of Health and Human Services (HHS) enforcement of the Emergency Medical Treatment and Active Labor Act (EMTALA). As frontline health care providers, the federal EMTALA statute protects your clinical judgment and the action that you take to provide stabilizing medical treatment to your pregnant patients, regardless of the restrictions in the state where you practice.

The EMTALA statute requires that all patients receive an appropriate medical screening examination, stabilizing treatment, and transfer, if necessary, irrespective of any state laws or mandates that apply to specific procedures. It is critical that providers know that a physician or other qualified medical personnel's professional and legal duty to provide stabilizing medical treatment to a patient who presents to the emergency department and is found to have an emergency medical condition preempts any directly conflicting state law or mandate that might otherwise prohibit such treatment.

As indicated above and in our guidance[1], the determination of an emergency medical condition is the responsibility of the examining physician or other qualified medical personnel. Emergency medical conditions involving pregnant patients may include, but are not limited to, ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders, such as preeclampsia with severe features. Any state laws or mandates that employ a more restrictive definition of an emergency medical condition are preempted by the EMTALA statute.

The course of treatment necessary to stabilize such emergency medical conditions is also under the purview of the physician or other qualified medical personnel. Stabilizing treatment could include medical and/or surgical interventions (e.g., abortion, removal of one or both fallopian tubes, anti-hypertensive therapy, methotrexate therapy etc.), irrespective of any state laws or mandates that apply to specific procedures.

Thus, if a physician believes that a pregnant patient presenting at an emergency department, including certain labor and delivery departments, is experiencing an emergency medical condition as defined by EMTALA, and that abortion is the stabilizing treatment necessary to resolve that condition, the physician must provide that treatment. And when a state law prohibits

[1] *Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss* (QSO-21-22-Hospitals- UPDATED JULY 2022), available at https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/reinforcement-emtala-obligations-specific-patients-who-are-pregnant-or-are-experiencing-pregnancy-0

abortion and does not include an exception for the life and health of the pregnant person — or draws the exception more narrowly than EMTALA's emergency medical condition definition — that state law is preempted.

The enforcement of EMTALA is a complaint driven process. The investigation of a hospital's policies/procedures and processes, or the actions of medical personnel, and any subsequent sanctions are initiated by a complaint. If the results of a complaint investigation indicate that a hospital violated one or more of the provisions of EMTALA, a hospital may be subject to termination of its Medicare provider agreement and/or the imposition of civil monetary penalties. Civil monetary penalties may also be imposed against individual physicians for EMTALA violations. Additionally, physicians may also be subject to exclusion from the Medicare and State health care programs. To file an EMTALA complaint, please contact the appropriate state survey agency[2].

EMTALA's preemption of state law could also be enforced by individual physicians in a variety of ways, potentially including as a defense to a state enforcement action, in a federal suit seeking to enjoin threatened enforcement, or, when a physician has been disciplined for refusing to transfer an individual who had not received the stabilizing care the physician determined was appropriate, under the statute's retaliation provision

As providers caring for pregnant patients across the country, thank you for all that you do. The Department of Health and Human Services will take every action within our authority to protect the critical care that you provide to patients every day.

Sincerely,

/s/

Xavier Becerra

[2] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/ContactInformation